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AUGUST, 1940

The First Institute of Podiatry
Long Island University

Commencement Exercises for the Class of 1941 will be held on Tuesday, June 3rd, 1941, at The Town Hall.

On September 23rd, 1940, the course at The Institute, under the new auspices, is to begin. All students admitted to this course must have had a minimum of two years at a college of the Arts or of the Sciences, and at the termination of the three years course, having met all of our exactions, their diplomas will bear the degree of Doctor of Podiatry.

Those anticipating attendance upon the annual convention of the N.A.C. in Boston, are invited, on their return journey, to visit The Institute, where they will be welcome.

Practitioners who are desirous of specializing in any of the sub-branches of podiatry-chiropody will find an outline of our Practitioners' Courses in our 1940-41 Annual Announcement, a copy of which will be sent to any practitioner requesting the same. All instruction in these courses is individual.

Representatives of The First Institute of Podiatry will be available at the N.A.C. Convention in Boston to all in attendance desirous of ascertaining particulars regarding the course at The Institute.

The Journal of Experimental Podiatry, Volume I, No. 2, is now ready for distribution, and those desiring a copy of the same should address the authorities of The Institute.

For Annual Announcement, address

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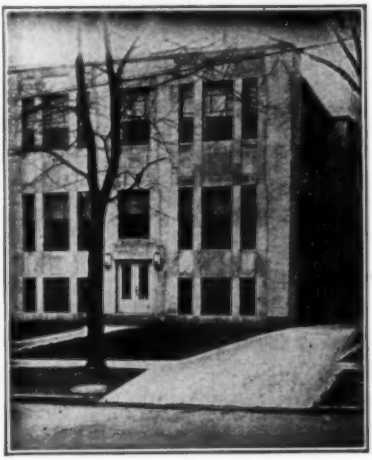

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MATERIALS FOR ORTHOPEDIC CASTINGS

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THIS PAPER on orthopedic castings is devoted to the prosthetic side of the subject. It is necessary for any practitioner to have some knowledge of materials that are used in the taking of impressions for orthopedic appliances, therefore I present a short resumé of nomenclature and substances that one must deal with in his everyday practice.

To some this may seem elementary, but to others it is a necessity. The differentiation between an impression and a cast:

AN IMPRESSION is a negative likeness of an object or part taken in plastic material, from which a cast or positive likeness may be produced.

A CAST is a reproduction, in plaster of Paris, its compounds or some plastic materials, of an object or a part made from an impression or mold.

Materials

The materials used for taking impressions, making casts or models, need careful consideration that they may be intelligently manipulated, thereby securing the best results.

There are two classes of materials used for taking impressions. First, those substances made pliable by heat, and that harden by cooling, and second, materials made plastic by water and that harden by crystallization.

Materials of the first class are, wax, gutta-percha, modelling compound. The latter is used to a greater extent in chiropody, while plaster of Paris is the one material of the second class. This material being of the utmost importance to our profession, it will be necessary for me to devote the greater part of my lecture to the chemistry and uses of this important impression material.

Wax is a general term applied to a solid fatty substance obtained from all three kingdoms of matter. The general properties of the various substances called wax, are easily broken when cold, but at a moderate heat are soft and pliable.

Beeswax is an animal secretion formed by bees from sugar, and is the material of which the honeycomb is formed. It is obtained by expressing the honey and fusing the residue in water. In this state, it is of a yellowish color.

Vegetable wax. These waxes may be obtained from several varieties of plants. They are of no value.

Mineral wax. This is of natural material known as azocerite, and is a waxy translucent mixture of the paraffins of coal formations.

Modelling compound. This material is a composition of a resinous gum, as copal, damma, etc. with stearic acid and French chalk, colored and flavored.

Modelling compound is softened in water after the manner described as the method for softening wax. Chiropody compound melts at 115°-117° F. Dental compound melts at 135°-137° F. The surface of the compound just before using, should be passed over a flame. As the softened modeling compound is liable to adhere to the bottom of the pan, it is a good plan to place one end of a strip of white paper in the pan for the compound to rest upon. The other end is a convenient means for withdrawing the compound from the hot water.

Gutta-percha. The gum is in many respects similar to caout-chouc. The former is only slightly elastic, while the latter has almost perfect elasticity.

Plaster of Paris is made from the mineral called gypsum. This mineral is found in various forms, as massive or rock gypsum, alabaster a pure white fine-grained massive gypsum, and selenite, a crystalline, almost transparent gypsum. The chemical formula of pure gypsum is $CaSo_4$-$2H_2O$. Therefore, pure gypsum is hydrous sulphate of lime, made up of one molecule of calcium sulphate combined with two molecules of water. This, when reduced to percentages of weight corresponds to calcium sulphate, 79.1% and water 20.9%.

Properties of Orthopedic Plaster

Gypsum products, to be suitable for orthopedic purposes, should possess certain properties, and a special brand is of value only as it meets the requirements. It should be free of all foreign substances (as dirt and fibrous matter), sufficiently ground to form a smooth mix, quick setting, generate but little heat, minimum change of form while crystallizing, and sufficiently resistant to any stress to which it may be subjected.

There are three different requirements of practice that make a demand for as many classes of plaster: (1) for impressions the plaster should

be quick setting, expand but little, not contract, (2) for casts the plaster should be as little changeable, while crystallizing and stress, as possible, and (3) for flashing and luting a medium between the preceding two is required. However, the first class of plaster may well, and can, be dispensed with by adding a chemical substance to a well chosen third class of plaster, and is used for impressions. In fact, a strictly impression plaster is a dangerous article in the laboratory, as it is unfit for casts and is apt to be improperly used. The addition of sodium chloride or potassium sulphate to a high grade suitable plaster answers well for impressions.

If plaster bandages are to be used merely for an impression of a part from which a cast is to be made, it is desirable to apply them directly to the part.

Separating Mediums

The object of the separating medium is to treat the surface of the impression that a perfect counterpart of the intaglio may be formed of plaster or its compounds, and the two easily separated. This is accomplished by flowing over the surface of the impression some material that will prevent adhesion of the added plaster. The desirable properties for a separating medium are as follows: (1) it should add as little substance to the surface of the impression as possible, (2) it should provide a line of demarcation with a distinct penetration of the impression, (3) it should not cause chemical changes and injurious effects upon the surface of the cast to be constructed over it, and (4) it should give a smooth glazed surface to the cast.

There are a great variety of materials recommended and used for this purpose, but few are extensively used. They may be classified as: Alcoholic solutions: (a) shellac, and (b) sandarac, and (c) other gums and terpenes added to these foundation solutions. Aqueous solutions: (a) liquid silex, silicate of soda, (b) soap, (c) borax or shellac, (d) ammonia or other alkaline substances and shellac. Oils, as sperm, lard, sweet, vaseline, and ethereal solutions: (a) of soap and (b) collodion. The aniline dyes are used as coloring matter for some of these preparations. Many of these preparations are kept in stock by the supply houses, and some of them under fanciful names. Perhaps the best and most commonly used medium in orthopedic practice is the ordinary talcum powder.

Pouring the Impression

This is a common term used for filling the impression. The term is slightly misleading in that it implies that the plaster mix is poured into the impression. The plaster batter should be a little thicker than for an impression, and a trifle too thick to pour. However, it must not be so stiff that it will not flow perfectly over the surface of the impression when jarred by rapping the plaster cast lightly on the table. The same rule as to ratio of water and plaster is used for impressions, i.e., one measure

of water and two measures of regular orthopedic plaster. If the mix seems too thin more dry plaster should be added until the mix will stand as placed. However, it must have a pronounced glossy or watery appearance, and when this characteristic diminishes it is evidence that either too much plaster has been added or that crystallization has commenced. The surface of the impression should be thoroughly covered before this deadened appearance begins. The student should observe carefully the appearance of his plaster mixes, because the quality of the cast depends much upon the manipulation. An excessive amount of plaster added to the water, or over-spatulation interferes with the process of crystallization, thus causing increased expansion and reduced strength of the cast.

The Setting Stage

There has been some confusion as to what is meant by the setting time and when it occurs. This particularly applies to its determination on the bandage cast. In order to clearly follow the various changes experienced by plaster of Paris after mixing with the water, the process is divided into five parts or stages quite well defined by certain physical properties, such as, the liquid, pasty, weak, solid with moisture, and dried cast stages.

Assuming that an average quantity of water, say 60% to 65% of the weight of the plaster used, the resulting mixture is liquid, soon changing to a pasty solid. During these two stages the application of the bandage is made. During the latter part of this time the needle-like crystals begin to form. A pasty mixture of plaster and water can also be made by using less water, and under these circumstances, there would be no liquid stage. The third stage starts at a point where brittleness can be noticed, or where the plaster has a tendency to crumble, and ending when the crystallization of the calcium sulphate is complete in the presence of all the water used in the cast.

The final set occurs just at the end of this period, the cast having at this point developed one-half of its full strength. At the end of this period and extending for some time after, a constant strength is shown. It is during this period at some point where the plaster is increasing in hardness, strength or set, that the setting time of the bandage is estimated, generally by simply feeling the hardness of the cast.

The Uses of Plaster of Paris Bandage

There are many conditions met with in general and orthopedic surgery where this type of dressing is of use. A plastic dressing is of course rigid after it is applied and has set. It can be used for protection, support, immobilization or correction of deformity. The methods of application will naturally vary with the individual surgeon and with the particular lesion.

As has already been pointed out it is important to keep plaster bandages dry so that the water driven off during the preparation of the plaster shall

not be reabsorbed, which would hinder setting. It is also essential that unnecessary handling be avoided particularly after the removal of the wrapper so that the plaster will remain in the meshes of the crinoline.

Dry plaster, although clean, can easily be scattered like any other powder and in that way is considered dirty. Plaster, when wet, is somewhat messy and one must be careful not to spill it about.

Before applying bandages it is best to protect with sheets, towels, etc., except where the cast is to be used. The operator and assistants had best have their arms bare, wear gowns and aprons and even rubbers to cover their shoes.

The table, bench, chair or other furniture used, as well as the floor, can be well protected with sheets, rubber sheeting or ordinary newspaper which are always available.

When feasible, a good clear sunny day is preferable to damp weather as the plaster will then set and dry more rapidly. It is important to have everything ready before the application is started for when it is once begun the operator must work rapidly. After all of the surroundings are protected the bandages can be opened and laid out within reach. Care must be taken to prevent splashing them with water. The material used for padding should be at hand and the water prepared. A pail or basin can be used: water at room temperature is preferable. The water must be deeper than the width of the bandages being used for when they are immersed they are stood on end and must be entirely under water.

Application of the Bandages

If plaster bandages are to be used merely for impression of a part from which a cast is to be made, it is desirable to apply them directly to the part, protecting it only by a separating medium.

After the part and the surroundings are prepared, the operator is ready to proceed with the plaster. It must be borne in mind that at best a cast is heavy, cumbersome, and unsightly, so one must attempt to keep these features at a minimum. Try to make the cast as thin and light as possible and yet strong enough to last and to serve its purpose. Reinforcements, which will be described later, often enable one to make a cast very strong, yet thin and light.

The plaster must be carefully molded and rubbed all during its application up to the time of setting to make each ply of bandage adherent to the next and to have the cast fit well and hold its position. Although not essential, it is nevertheless well to make a cast look well finished as you may frequently be judged by the appearance of the work.

Immersion of the bandage is done after the outer wax covering is removed. It is placed in the pail or basin of water on its end; it is allowed to remain soaking until all bubbling stops. When it remains much longer than this it begins to set. If the operator is working

rapidly, the second bandage may be immersed when the first is removed from the water and so on.

Removal of the bandage from the water must be done with care. It should be picked up and held with one hand over each end. It is then squeezed, but not wrung, to remove the excess water, at the same time endeavoring to retain all of the plaster in the bandage. Usually a little practice will determine just how hard to squeeze the bandage. In general it may be said that the drier the bandage, the quicker it will set, but care must be used not to squeeze it too dry.

Dry spots in the bandages will be found if water has not penetrated the entire roll, this due to its being removed too soon from the water. In hand rolled bandages, of course, this might be due to the fact that they are not evenly rolled as is the case with machine rolled bandages. When dry spots are encountered, they may be moistened by dipping out a little water with the hand and rubbing it on. There may be a slight shortage of plaster in the first few turns of the bandage as this is the part where it easily falls out or is squeezed out in handling.

The bandages should be rolled in circular fashion, care being taken to avoid unevenness especially in the first few layers where such irregularities might tend to cause pressure. They must not be rolled too tightly, nor yet too loosely; in the former case there might be pressure or construction, whereas in the latter case it might not hold enough to sufficiently perform its function of immobilization or deformity correction.

Reversing the roll as is often done with ordinary bandage should not be done with plaster bandages. If the roll is not going along in the direction desired it is best to cut it and start again or else make use of darts or reduplications on one side only to change the direction. Every turn of the bandage should be well rubbed so that they will all become as one solid mass without spaces between them. It is a definite fact that the more rubbing, the fewer bandages one uses to get a strong and nice appearing cast.

Splitting and Removal of the Cast

In many cases it is not desirable to leave on a circular cast, especially in some of the acute conditions such as fractures where swelling may occur. Here the cast is split immediately with a knife, saw or plaster shears. It can be then spread as much as necessary. It is even better in such cases to bivalve the cast, i.e. to cut it down on both sides so that either half may be removed. The two halves can be held in place with adhesive strips or bandages.

The embedding of a metal strip under a cast at the point where it is to be split, so that there is no likelihood of cutting the skin, is unnecessary if due care is used in cutting. A few surgeons like to embed

a Gigli saw under a cast and cut through in this fashion, but as a rule it is a risky method.

The method for removing a cast is the same as for splitting it. Here again it is more desirable to cut in two opposite lines so that it is bivalved. If a single cut or split is made it is necessary to use some force in spreading the cast enough to remove it; this may be detrimental to the part and often causes the patient undue pain or discomfort.

Effect of Added Substances

An increase in the amount of water retards the setting of the plaster, for the initial and the final set. An increase in the water content weakens the cast; the variation in strength is not proportionate to that of the water. The strongest casts are those made with the least amount of water that can be used, providing a thoroughly even mix is obtained and the cast made before the setting has gone very far.

Under ordinary conditions the temperature of the water has little effect upon the setting time of the cast, but becomes pronounced in lessening the setting time when it is used at about the boiling temperature, assuming that the plaster is at ordinary room temperature.

Of all the accelerators and retarders in use, common salt is probably best known. It very efficiently accelerates the setting of plaster. A quantity of salt equal to 1% of the plaster when dissolved in the water of the mixture hastened the initial set of the plaster from 8 minutes to 3 minutes and hastened the final or true set from 14 minutes to 6 minutes. When large amounts of salt are used the setting time is retarded. The cast made, using salt as the accelerator, has approximately the same strength as pure plaster before it developes the final strength due to water evaporation. The final strength, however, is from 5% to 20% weaker.

Among the active accelerators may be mentioned alum, calcium chloride, magnesium sulphate, ammonium chloride and hydrochloric acid. Any salt which increases the solubility of plaster of Paris in some measure accelerates the setting, but probably the best accelerator is finely ground gypsum, incorporated with the plaster at the time of manufacture. The fine particles of gypsum mixed with the plaster act as nuclei for the starting crystallization from the super-saturated solution. Casts made using this accelerator are usually as strong as those using the pure plaster.

Summary

1. The hardening or setting of plaster involves five distinct stages.
2. Three to four times the amount of water necessary for the set is required to make a workable mixture.
3. The development of strength in a cast is closely linked with the crystallization of calcium sulphate.

4. Gypsum and common salt are effective accelerators.
5. Increasing the amount of water mixed with the plaster decreases the strength of the cast.
6. A rapid setting develops higher temperature.
7. Certain materials do not affect the setting time of the bandage cast.
8. Uniformity of construction of the plaster bandage is essential to secure strength.
9. An ounce of plaster to 120 sq. in. of crinoline surface has been found the best proportion of plaster for the bandage.
10. The principal features of the strength curve are its initial rigidity, the cracking point of the plaster, and the crushing pressure necessary to collapse it.
11. Thorough squeezing of the soaked bandage without plaster loss, tightly wrapping the bandage, and perfect contact between layers tend toward greater strength.
12. Increasing the number of plies from five to seven in a cast doubles its strength. Nine plies trebles its strength.

45 Paterson Street

Read before the convention of the Chiropodists Society of the State of New Jersey.

ETIOLOGY OF HALLUX VALGUS

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ONE OF THE most common afflictions of our race is a condition known as hallux valgus. This is defined as a deformity in which the great toe is deflected to the outer side of the foot and is kept in this position by accommodative changes in the structures forming the first metatarso-phalangeal joint and those acting upon it. Of all the tribulations to which the human family is heir, none is more frequently met than this condition. Many patients suffer agonies from this deformity and often seek the advice of a skilled practitioner for relief. All of us know how a sore corn entirely unfits us for our daily tasks. This is equally true in the case of an inflamed first metatarso-phalangeal joint. Thus, it is advantageous for chiropodists to be thoroughly acquainted with the factors of these cases since this condition is seen so frequently. However, before we can properly correct this deformity the cause for its development must be carefully analyzed.

The foot in its primitive state had the great toe perfectly straight. If this foot had remained in sandals or straight shoes, there never would have been such a thing as a bunion that would need serious attention. In the pedal extremity of an infant the long axis passes through the great toe and if this axis is prolonged centrally in its posterior aspect, it should pierce the middle portion of the lower border of the heel.

In practically every shoe-wearing adult, though, there is a variation from the normal in this line, so that at best there exists a slight or moderate displacement of the great toe. Only however, when this displacement attains a degree of deformity, do we find a condition of true hallux valgus.

Hallux valgus is a static weight deformity caused by the little toe walk which is taught us from youth. When the foot is abducted and placed in a position of strong external rotation the heads of the fourth and fifth metatarsals first come into contact with the ground. The contraction of the muscles which follow brings about a supination and by the counterpressure of the ground the heads of these two metatarsals are forced upward. The foot assumes a position of pronation until the whole weight of the body falls on the head of the first metatarsal. In the same degree that the distal part of the first metatarsal yields in an inward direction, the basal phalanx is deviated outward by the action of muscle and shoes. The deviation is retained by changed skeletal conditions and altered traction of the musculature. These theoretical diagnoses may be confirmed by roentgenograms. In a hallux valgus which is bearing weight there is a uniform divergence of all the metatarsals. Aside from the extreme lateral deviation of the first phalanx there is also a lateral deviation of the second to fourth phalanges, while the fifth seems to be deviated in the median direction. The head of the first metatarsal no longer articulates completely with the base of the first phalanx which is displaced in the direction of a beginning subluxation inward.

In all cases of hallux valgus there usually accompanies either pes planus or at least drop foot which may itself lend to the development of this condition and which, together with the genu valgum, gives the impression of an asthenia of the whole ligament structure. In pes valgus the feet are put down in a position of abduction. They are rolled over on the internal border and hallux valgus deformity formation begins.

Hallux valgus is commonly seen in the patient with a weak anterior arch. There is often a flattening behind the metatarsal heads instead of a slight convexity. Often very thick callous formation is noted beneath the heads of the four outer metatarsals. Frequently there is a tendency for the proximal ends of the phalanges to be depressed into the sole of the shoe, the angle which they make with the metatarsals being nearly a right angle. The great toe is apt to rotate to such an extent that the weight is borne on the outer side of this member rather than upon its plantar surface. Most conspicuous of all is the tendency to redness and bursal thickening over the inner aspect of the great toe and occasionally over the head of the fifth metatarsal. Occasionally

these become infected and the bursa suppurates. Associated with these static disturbances in the great toe are to be noted corns and callosities on other toes which in themselves are painful and seriously impede locomotion.

Etiologically, ill-fitting shoes are the prime factor in the production of hallux valgus. Civilized man, because he walks shod in the stiffened leather of the boot or shoe, pays the penalty with a host of pedal defects and deformities. Among uncivilized races who go barefoot and among infants, the position of the great toe in its relation to the foot as a whole differs from that found among those of us whose years and environment have demanded more conventional modes of footgear than nature has provided.

The pathological changes resulting from improperly fitted shoes are naturally more common in women. Most of their footgear narrow from a point about opposite the first metatarso-phalangeal articulation forward to the tip of the great toe. A similar curve is observed on the outer side of the foot from the fifth metatarso-phalangeal joint forward. Since the anterior arches of these individuals spread laterally and the thrust of the foot as one rises on the toes tends to crowd the forefoot toward the front of the shoe, where it is narrowest, you have factors operating which combine to produce this deformity. Complications start at the base of the first metatarsal and first cuneiform progressing forward. A relaxation of the adductor muscle takes place and a loosening of the facial attachments. The foot becomes pronated, the anterior transverse arch becomes depressed, the toes become contracted, together with the tendo achilles and plantar fascia. As a result there is imperfect tendon balance and formation of a hallux valgus. The narrow, pointed shoe and short, tight stockings only contribute and aggravate the already existing effect.

Inflammatory changes are also a common cause for hallux valgus, namely arthritic and inflammatory reactions to bacterial invasions. The alterations producing this condition are classified as: 1. circulatory, 2. bursitic, 3. gouty, 4. traumatic, 5. arthritic.

Circulatory disturbances causing hallux valgus produce an endarteritis obliterans with spasmodic contractions of foot and leg muscles. Arteriosclerosis and varicose veins are often seen in conjunction with this abnormality. The differential diagnoses of these types is quite simple but nevertheless, very important. X-ray findings will eliminate the arthritic variety including the gouty joint. A bursitis involves the synovial lining and is easily ruled out, while infected bursa are characterized by the presence of suppuration. The diagnosis of the traumatic type is self-explanatory. Fractures of the head of the first metatarsal bone which will result in the outward displacement of the phalanx have created this deformity.

Dwight's wedge-shaped bone (metatarso-cuneiform wedge), a supernumerary bone which is sometimes found at the base of the first metatarsal, must be considered at least as a predisposing, if not direct cause. This wedge causes the first metatarsal bone to form an angle with the first cuneiform. This brings the first metatarsal into abduction. When a foot in which the first metatarsal bone is abducted is subjected to the restriction of the modern sock, or when it is placed in a shoe that does not permit of abduction of the great toe under weightbearing, as would be normal in this case, then hallux valgus would be produced much more readily than in the average foot.

Occupation has no direct effect on the production of this condition but all forms of foot deformity are more marked in those whose work entails long periods of standing or walking. This abnormality is perhaps more likely to occur in those whose feet are constantly active than in those whose employment demands prolonged standing and weightbearing.

There is no doubt that atmospheric conditions are productive of pain, especially where there is humidity. The feet are perhaps more subject to the effects of extremes of temperature than other parts of the body. One can hardly be surprised that the effects of chill may be evident when a bath is taken at, say 98° or 100° F., and within a few hours the same feet, thinly clothed come in contact with a pavement or roadway at a temperature approaching freezing point. It is not to be wondered, therefore, why chiropodists notice a greater frequency of joint affections resulting from chill during the winter months. There is no doubt that at high altitudes joint troubles are less, whereas on lower levels, especially near a river or on clay soil, they are much more prevalent.

Whether or not hallux valgus or a tendency toward it can be inherited is a topic that is still disputed. The opinion of some authorities in certain cases is that there is an hereditary weakness of the ligaments, allowing a stretching of the capsule surrounding the joint and the inevitable dislocation of the same. The type of foot which lends itself to the development, under the right sort of stress, of this deformity is probably what is inherited, not the deformity itself. These conclusions would seem reasonable since this condition is found occasionally as a family characteristic extending through several generations. This abnormality, if seen in children, usually rights itself when the child wears his first shoes.

It is in the growing stage, particularly, that tendency towards hallux valgus seems to begin. At the present time, although more attention is given to children's footwear and to the needs of their feet, it is quite possible that the chiropodist may meet with cases of slight deviation of the great toe in which there is no pain and which possibly may pass unnoticed. This deviation perhaps may have been induced by shoes

and hose which originally were of proper length, but owing to rapid bodily growth or shrinkage of the hose, have become too short, so that the yielding character of the foot, accommodating itself to this condition, lends itself easily to adduction of the great toe. In this connection it is well to remember that bodily growth is generally preceded by lengthening of the foot, which is sometimes more rapid at certain stages than at others.

It is obvious that the primary deformity gives rise to secondary changes in neighboring structures. The pressure on the soft parts on the outer side of the toe causes the nail to penetrate the tissues and produce the painful affection of ingrowing toe nail. The continued pressure on the second toe causes it to assume a cramped position which, in time, results in hammer toe. Again, pressure effects lead to the development of an exostosis at the internal portion of the head of the first metatarsal bone and the production of an enlarged bursa or bunion, which may become inflamed and suppurate. It is interesting to note that when once the great toe deviates outward, then the extensor hallucis longus tendon exaggerates the condition and is an important factor in its further progress.

Persons having a hallux valgus condition suffer severe pain. They cannot stand or walk without having great discomfort. There is not only difficulty in walking but a loss of elasticity in the gait and almost constant pain in the affected joint and the neighboring toes. These patients are great sufferers and in consequence their general health deteriorates and shares in the local misery.

Since this lesion will grow progressively worse unless it is properly treated, it is our duty, as chiropodists, to carefully analyze hallux valgus in regards to the cause for its development. For if we fail to remove its etiological factors, we can not sustain a cure. Therefore, since these factors are the primary principle in determining treatment, let us keep the causes of hallux valgus fresh in our minds to insure the success of our therapy.

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THE FIRST INSTITUTE OF PODIATRY

Affiliated with Long Island University

MAURICE J. LEWI, M.D., President
New York, N. Y.

THE FIRST INSTITUTE of Podiatry, originally the New York School of Chiropody, came into existence under a law effective January 1st, 1913, at which time the writer became its executive officer.

Promptly upon assuming his duties, the President, in cooperation with Augustus S. Downing, Assistant New York Commissioner of Education for professional education, mapped out a program to be followed throughout the years.

The original academic qualifications for admission to The Institute were one year of high school and a course of study over a period of one year. Gradually, these qualifications were increased and under the terms of a bill, presented by the legislative committee of the New York State Podiatry Society and approved by The Institute authorities and passed by the New York State Legislature in 1936, effective September 1940, the minimum academic qualifications for admission to The Institute were fixed at two years of college work and the course of study was fixed at three years, "in accordance with the requirements of the department and leading to a doctor's degree in podiatry".

Under the University law, regardless of any other requirements, no institution chartered by the Regents of the University of the State of New York, is permitted to grant a degree of any kind unless it has assets representing a minimum of $500,000. The Institute did not have such assets, its holdings in cash, in buildings and in paraphernalia, representing a monied value of less than $300,000.

Accordingly, in order to meet the requirements of this law, steps were taken about two years ago, to arrange for affiliation with a University chartered as such by the University of the State of New York. Negotiations to this effect, pending with Long Island University over a period of more than a year, were finally concluded by action of the respective Boards of The Institute and of the University, and on November 16th, 1939, the Regents of the University approved of the merger of the two units mentioned and since that time, The Institute was and continues to be a college of Long Island University, specializing in the education of podiatrists (chiropodists).

In the newer dispensation, after September 23rd, 1940, the academic preliminaries for admission to The Institute will be practically the same as the pre-medical requirements. The last of the three courses at The Institute will be of 11 months duration, the last three months of which will be devoted exclusively to practical instruction, these latter activities being the equivalent of an interneship.

The new curriculum will include the study of bio-chemistry, inorganic and organic chemistry becoming a part of the required pre-podiatry education.

It will be of interest to the members of the podiatry profession to learn that no change whatsoever has been made in the direction of the affairs of The Institute by reason of its University affiliation, excepting that our governing board will have available for consultation and advice, the President and the Board of Trustees of the University as well as

the like services of Dean Metcalfe of the University. By virtue of the merger of The Institute with Long Island University, all of the effects of The Institute become a part of the effects of the University.

The Administrative Committee of The Institute takes the place of the former Executive Council, now consisting of Dean Metcalfe, Dean Gross, Registrar Sonderling, Bursar Schmitt and the undersigned. Thus, it will be noted that there is no change in the personnel of The Institute's governing body since the former Board of Trustees now becomes the Executive Council. There is every reason to assume that this pleasant relationship will continue on indefinitely.

The Foot Clinics of New York still retain their separate identity as a charitable organization governed by a separate Board of Trustees, as licensed by the New York State Department of Social Welfare. The conditions of association between The Institute and The Clinics provide for the housing of the latter in the quarters of The Institute, as heretofore, for an initial period of five years, with the understanding that The Clinics will pay the sum of $3,000 annually for their share of the upkeep of both units. There is every reason to suppose that these arrangements will be continued on as each term of the five years' contract expires.

Neither The Institute nor the University has any authority whatsoever over The Clinics, excepting as provided in the agreements as to association. Thus, the management of The Foot Clinics of New York remains exclusively in the hands of its Board of Trustees of 15 members, 13 of whom are practicing podiatrists.

A MESSAGE ON PODIATRY

MILTON LOOMIS, M.D.
Associate Commissioner of Education
of the State of New York*

FROM TIME to time it seems desirable to clarify the understanding of professional people as to the relation of the State Education Department to professional groups and their problems. It also seems timely to outline briefly the philosophical basis of the attitude of the Education Department in the practical administration of its responsibilities and functions as defined by the professional laws. I plan to do this tonight in reference to the profession to which this organization is devoted, podiatry.

In the first place, it is to be noted that the Department is legally responsible for the enforcement of the educational requirements demanded for admission to the professional study of podiatry. These requirements have been progressively increased since 1912 when one year of high school study was the modest demand of the law. In 1917 this was increased to two years of high school, in 1919 to three years, and in 1921 to graduation from a four-year high school course approved for the purpose. When this last requirement went into effect, an approved high school course was defined as one including certain required studies (in English, languages, mathematics, science, history, and civics) amounting to 9 or 9½ units, with the rest of the course elective. In 1937 the First Institute of Podiatry took the courageous and forward-looking step of requiring, without legal compulsion, one year of college

study as prerequisite for admission. When this step was taken, neither the First Institute nor the Department established any specific subject-matter requirements in connection with the requisite college year. As you all know, in 1938 the law was amended to provide, among other things, that the study of podiatry should be based upon two years of college study, beginning with September, 1940. In view of this statutory provision, the Department has abandoned its subject-matter requirements so far as high school study is concerned, permitting the college in which the required two years' work is to be done to be the judge of the adequacy as to quantity and quality of the high school preparation, under very general regulations controlling the admission of students to college study. However, the Department has recently applied the regulations as to prescribed college subject-matter for admission to medical study to students planning to enter upon the study of podiatry, effective September 1, 1941. These prescriptions involve 30 semester hours, 6 each in English, physics, and biology, and 12 in chemistry.

The Department believes that these minimal prescriptions as to subject-matter are sound and necessary. They assure that the student of podiatry will have at least a preliminary groundwork in the basic sciences, and so relieve the professional school from the necessity of including elementary work in such sciences in its program. Thus the requirement should make it possible greatly to enrich the content of the professional course, even though its length is not increased.

The Department is prepared to recognize that the purpose of subject-matter prescriptions is to assure a reasonable standard of competence in the subject, not the mere acquisition of credits. It is prepared, therefore, to accept in lieu of credits definite proof of competence as revealed by other evidence. It has been fairly well established that subject-matter examinations, prepared and administered by either the college or professional school are not evidence which can be accepted in place of the completion of college courses. However, standardized, comparable, objective tests, such as the sophomore tests of the American Council on Education, are available, and evidence of relative success in such tests, to be specifically approved by the Department, would be an acceptable indication of competence in the field or fields tested. Of course, proved ability in all the specific subject-matter fields prescribed will be insisted upon, and the statutory requirement of a full two-years of residence and credit in a college of liberal arts could not be abated under any circumstances.

In other words, the Department is prepared to recognize the validity of the findings of modern research to the effect that knowledge and ability in a given field of study are not the result alone of the completion of college courses in that field. Perhaps unfortunately, we are not prepared as yet to act on the growing body of evidence indicating that the completion of college courses is itself not adequate evidence of competence in the subject-matters of the courses. We will continue, at least for a while, to accept college credits at face value.

It will be noted that the Department's prescription covers only half of the two preliminary college years. It is hoped that in podiatry the course commonly followed in the preparation of medical students will be avoided. Pre-medical students, due in part to the attitudes of the

. . . *Please turn to page 32*

The Journal of the

National Association of Chiropodists, Podiatrists

Published under the Direction of the Council
by the National Association of Chiropodists

Joseph Lelyveld, Editor, 321 Union Street, Rockland, Massachusetts
A. R. Morley, Business Manager, 607 Fifth Avenue, New York, N. Y.

Articles intended for publication in the pages of THE JOURNAL should be addressed to the Editor. All advertising, business or subscription matter should be sent to the Business Manager.

BUSINESS AT BOSTON

When the N.A.C. meets in Boston later this month many are the matters to come before the House of Delegates and special committees for action. There is the matter of a uniform designation for our profession, so freely discussed in earlier issues of this and other journals. Whether we are to be known as chiropodists, podiatrists, pedists, or podists, will be decided during this centennial year once and for all. It is doubtful if so vital a question could or even should be settled by the delegates. They will be asked to authorize a survey, to poll all chiropodists in the United States, thereafter to adopt the designation preferred by three-fourths of the sixty-five hundred chiropodists licensed to practice in this country.

Then there is the long fought activity to establish a Chiropody (Podiatry) Corps in the United States Army and Navy. Turned down again by the powers-that-be at Washington, the delegates can do no more than to adopt an alternative; namely, to enlist a corps of chiropodists from all sections of the country and offer a competently staffed unit in every state as a volunteer corps to serve the men in the state units of the National Guard. It is far better that we serve now the men who are defending our country

than to wait until such time as we are entitled to a commission with all the privileges expected for ranking officers. As citizen chiropodists, we should feel impelled to serve our country first by aiding the men called to her defense, and await the coveted commissions until such time as they have been earned.

Through the Committee of (state society) Editors, something may be done to improve the small but nevertheless important journals. State papers can become of great value once they grow out of the embryo experimental stage. Some of them stand improvement in both format and content. Some of the mimeograph sheets can hardly be read and are a loss to the efforts of the editors. Such papers reflect the state of maturity on the whole profession, and advertising poorly printed is a waste of money even though placed merely as a gesture of good-will. The committee may solve such problems in Boston.

Not the least of the problems to be handled in Boston is that of an adequate N.A.C. Department of Public Relations, equipped to establish proper relationship between the state societies and local newspapers and to see that Chiropody is recognized and represented in all movements intended to better the public health.

Again the House of Delegates must consider whether as an association the N.A.C. is sufficiently mature to warrant the appointment and employment of a Business Manager, sometimes called an Executive Secretary, one who is capable of discharging administrative duties, editing the N.A.C. publications, supervising the many committees, and aiding state societies in the enrollment of new members.

There is real business to be done in Boston. We trust the state societies have each selected their most competent members as delegates. These representatives will have an opportunity to lend themselves to the continued growth of the N.A.C. and to Chiropody as a profession.

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The Handclasp . . .

Where you and the Editor gather together to talk of many things

The man who lags behind and fails to keep up with current advances in chiropody reflects on his profession. When patients are referred to you by others and it comes to light that you are not familiar with and do not use the methods they employ, the patient has only one inference to make; you are not up to date. Come to Boston for the convention and get the last word in treatments and appliances.

A convention is an education

We quote without comment some lines from a state medical journal: "Repeatedly in these columns, the need for unity and active interest on the part of members has been emphasized. There are still too many physicians who are indifferent. In these times, medical societies cannot afford the luxury of having nominal members on their rolls. There is too much at stake. For, as was stated in an editorial which appeared in the MEDICAL ANNALS last month, the task ahead is not one for leaders in medicine alone but for the rank and file. Decisions which are made should represent the will of the majority and should have the support of all. Unless there is a general awakening to the truth of this statement, the medical profession may find itself in a situation which will be the lot of all disorganized groups."

An appeal for unity

A Public Speaking Bureau is one of the dire needs of chiropody. Few professional men are good speakers. Few even know how to organize an interesting talk. It would be a great boon to the prospective speaker and of immeasurable value to the profession if such a bureau were established. One of its functions would be to prepare talks or outlines for talks which could be sent on a moment's notice to anyone needing them. Another would be to make clippings, catalog them, and send them in bundles or packages covering any specified chiropodical subject to the man getting ready for a talk. With it could go one of the outlines. This plan is in effect in the A. M. A. and is said to be highly successful. It is one of the inexpensive ways of securing the publicity for which there is such a strong demand.

Talks must be interesting to hold an audience

In a small local meeting recently a new member bemoaned the fact of the cliques that exist both in state and national organizations. Cliques are, indeed, a menace to the advance of any work. With rare exceptions they are selfishly motivated, having more interest in promoting some pet scheme or some favored individual than in furthering the association itself. In a profession like ours cliques are particularly reprehensible because they are diverting to small, narrow interests, movements that affect the welfare of the great public.

Elect officers who have ability

On to Boston!

Century Celebration of Chiropodists
Twenty-Ninth Annual N.A.C. Convention
Hotel Statler, Boston, August 25-30, 1940

THE MASSACHUSETTS Chiropody Association, the National Association of Chiropodists, and the convention committees of both organizations invite you to come to Boston on August 25 to 30 to participate in the observance of the greatest event that has yet occurred to the profession, the 100th anniversary of the founding of Chiropody.

All arrangements for the event are complete; scientific, social, and business meetings. The House of Delegates opens on Sunday, the scientific features commence on Tuesday as scheduled in last month's issue. The Hall of Science will be set up Monday. Social activities are planned from Sunday on, continuing throughout the week for all who register. The Women's Auxiliary of the Massachusetts Chiropody Association has arranged its own elaborate program to entertain women of the National Auxiliary and the wives of visiting members and delegates.

Every phase of the development and advancement of the profession will be effectively exhibited at the coming celebration in the Hall of Science. While one hundred years does not seem a very long period of existence for a profession, to evaluate the progress of chiropody especially during the past twenty-nine years proves that its accomplishments compare favorably with those of the older professions.

The Boston convention welcomes all chiropodists whether or not they are members of the state and national associations. Provisions have been made for the registration of non-members and they will be accorded every courtesy and the fullest of privileges. We want every chiropodist to know the extent of progress made through organized effort, we wish them to benefit through the program scheduled to open in Boston on August 25.

All chiropodists are most cordially invited to *Come Back Home to Boston* to take part in the Century Celebration, and to participate in promoting the advancement which we are celebrating.

CONVENTION SPEAKERS

IN PREPARING the scientific program for the N.A.C. convention to be held in Boston later this month, Dr. Felton O. Gamble, Chairman, has endeavored to provide something of interest to all chiropodists. The lecturers selected are men and women who have made a special study of the assigned topics.

Hall of Science

Twenty-Ninth Annual Convention

National Association of Chiropodists

Hotel Statler, Boston, August 25-30

THE FOLLOWING features will be exhibited throughout the convention in the Hall of Science adjoining the lecture hall. These exhibits have been obtained for the convention by Felton O. Gamble, D.S.C., Chairman, N.A.C. Scientific Committee.

1. ORTHODIGITA: Dr. Harry A. Budin, New York, New York. Professor of Orthodigita, Long Island University College of Podiatry. Apparatus models and appliances.
2. FOOT PROPHYLAXIS: Dr. Gustave S. Braun, Pittsburgh, Pa. A Demonstration and exhibit by the originator of this new system of foot hygiene.
3. CHIROPODICAL ORTHOPEDIC STRAPPING: Dr. Ralph Dye, Sandy Lake, Pa.; Dr. B. C. Egerter, Pittsburgh, Pa. Demonstrations, models, and charts under the direction of the two foremost chiropodists in this field.
4. MANIPULATION: Dr. George C. Custer, Chicago, Illinois; Dr. Lester Walsh, Wilmington, Delaware. These men have had wide experience in Manipulation and will present modern techniques through a symposium.
5. INJECTION THERAPY: Dr. J. S. Bowman, Lebanon, Pa.; Dr. R. E. Fowler, Detroit, Michigan. This new science will be presented by men who have done original work and are carrying on constant research in this subject.
6. SHOE THERAPY: Dr. Frank Carleton, West Chester, Pa.; Dr. Merritt F. Garland, Haverhill, Massachusetts. Two nationally known authorities on the science of shoe therapy will present this topic. Demonstration, Models, Pads, and Corrections.
7. PRACTICAL FELT SHIELDING: Dr. G. K. Schacterle, Practical Demonstration of Chiropodical Padding for all types of foot conditions by a man who is a master of this science.
8. MECHANICAL ORTHOPEDICS: Dr. O. N. Schuster; Dr. J. J. Slevin, Jr. of New York City; Dr. Schuster, the author of "Foot Orthopedics" and his understudy, Dr. Slevin, will demonstrate the principles of mechanical orthopedics in connection with the construction and correction of foot appliances.
9. LIQUID LATEX SHIELDING: Dr. W. H. Woolf, New York, New York; Dr. G. B. Vosburg, Austin, Texas; Dr. Paul Koehler, Louisville, Kentucky. Demonstration, models, casts, and photographs. A non-commercial exhibit by leading men in this field.
10. DIAGNOSTIC ORTHOPEDICS: Dr. J. M. Gibb, Warren, Pa.; Dr. Harold W. Orr, Oil City, Pa. Dr. Gibb, the originator of Chiropody's finest diagnostic chart, with the assistance of Dr. Orr, a leading diagnostician, will demonstrate their system of diagnosis.
11. DIABETIC FOOT MANAGEMENT: Dr. John F. Kelly, Staff Member of the New England Deaconess Hospital, Boston, and Dr. W. D. Cogan,

Cambridge, Mass. The New England Deaconess was the pioneer foot clinic, sponsored by the Massachusetts Chiropody Association and functions under Elliott P. Joslin, M.D.

12. ROENTGEN INTERPRETATION: Dr. Felton O. Gamble, Collingswood, N. J. Author of many papers on Chiropodical X-Ray Technique and Interpretation. Exhibition of cases.
13. HYDRO-THERAPY: Dr. E. J. Martucci, Philadelphia, Pa. Dr. Martucci has long been identified with Hydro-therapy and has developed many specialized techniques which he will demonstrate.
14. PHYSICAL THERAPY: Dr. Ida R. Baker, Wilmington, Delaware; Dr. J. M. Horwitz, Philadelphia, Pa. Practical demonstrations. These prominent exponents of electro-therapy will give technique in Sine Wave Application and Galvanism.
15. ORTHO-HESIVE STRAPPING: Dr. B. C. Mullens, Binghamton, New York; Dr. I. Pashin, Poughkeepsie, New York. Photographs, models, and demonstrations. These men are the originators of this unique method of strapping.
16. PEDIATRIC FOOT ORTHOPEDICS: Dr. Eugene Rice, Washington, D. C.; Dr. John Sharpe, Philadelphia, Pa. Dr. Rice will read a paper entitled: "The Child's Foot Lesion With Relation to the Adult's Foot Suffering." Dr. Sharpe will exhibit his latest developments in the diagnosis of children's foot conditions.
17. SURGICAL ILLUSTRATIONS: Dr. Albert J. Kilberg, Camden, New Jersey; Dr. Jonas C. Morris, Audubon, New Jersey. Photographs and models. Complete chiropodical demonstration, with actual photos of each step.
18. ROENTGEN THERAPEUTICS: Dr. E. W. Demeur, Oak Park, Illinois; Dr. R. J. Quick, Detroit, Michigan. Safe and sane X-ray therapy. Charts and graphs depicting technique.
19. SHOE CONSTRUCTION: Dr. C. P. Leydecker, St. Louis, Missouri; Dr. Vincent Guy, Boston, Mass. A display of materials and methods used in the construction of shoes.
20. CHIROPODICAL PHARMACOLOGY: Dr. Harry L. Goldwag, New York, New York. Dr. Goldwag is Professor of Pharmacy and Materia Medica at Long Island University College of Podiatry. He will have an outstanding demonstration of new drugs and prescriptions used by chiropodists.
21. FOOT IMPRESSION METHODS: Dr. E. C. Meldman, Milwaukee, Wisconsin; Dr. Mathilda Miller, Hoboken, New Jersey; Dr. Morton Polokoff, Paterson, New Jersey; Dr. Carl Bergman, Chicago, Illinois. These Doctors will present an elaborate exhibition of every phase of foot impression methods. They are leaders in this field and will present a round table discussion of the subject.
22. ROENTGENOGRAPHIC TECHNIQUE: Dr. Felton O. Gamble, Collingswood, N. J. A complete series of charts will demonstrate the Standard Position Technique. Literature and reprints will be distributed.
23. CHIROPODY RESEARCH PROJECTS: Dr. Arthur Sharpe, Philadelphia, Pa.; Dr. O. N. Schuster, New York. The result of Dr. Sharpe's extensive research will be displayed with micro-photographs. Dr. Schuster will elaborate on his research in alkaline anaesthetics.
24. CIRCULATORY MANAGEMENT: Dr. T. J. Fletcher, New Castle, Pa. Author and Lecturer on the subject of Circulatory Management

will present this subject in graphic form. His exhibit will include an outstanding display that has received attention at A.M.A. Conventions.

25. CLINICAL PHOTOGRAPHY: Dr. Martin Glass, New York, New York; Dr. M. W. Shapiro, Toledo, Ohio; Dr. L. A. Frost, Monroe, Michigan. Through the courtesy of these experts in Clinical Photography, many of the foregoing exhibits have materialized. Through their kind cooperation, we have been able to display splendid photographs of many cases that otherwise could not be shown.
26. CHIROPODY COLLEGE EXHIBIT: All colleges of Chiropody have been invited to participate in the Hall of Science.

HONOR ELLIOTT P. JOSLIN, M.D.

ELLIOTT P. JOSLIN, M.D., of the New England Deaconess Hospital, Boston, will be honored at the annual banquet of the National Association of Chiropodists on Tuesday evening, August 27, with certificates of Honorary Membership. Because of his assistance in placing chiropodists on the staffs of hospitals throughout the country, the Massachusetts Chiropody Association had previously voted Honorary Membership to Dr. Joslin and presented his name to the N.A.C. for national honor which was voted by the House of Delegates at San Francisco.

NATIONAL FOOT HEALTH COUNCIL

INDUSTRIAL FOOT CARE will be discussed at a breakfast meeting forum conducted by the National Foot Health Council, on Wednesday morning, August 28th, at 8 o'clock, at the Hotel Statler, Boston. Dr. Joseph Lelyveld, Chairman of the Council, will preside at the forum. The discussion will include the importance of foot care in industry, and its relation to the employer; the value of supervised foot care to the employee; the prevention of foot defects in industry as a means of accident prevention, efficiency, increased earning power; and better workmanship resulting from organized foot care.

Reports will be given on the chiropodist's, podiatrist's relationship to medical industrial clinics. A plan will be presented for the placement of chiropodists, podiatrists in the employee clinics of department stores, also a plan to provide supervised foot care by chiropodists, podiatrists for industries manufacturing materials to be used in the national defense program.

AMERICAN COLLEGE OF CHIROPODISTS-PODIATRISTS

THE AMERICAN College of Chiropodists (Podiatrists) will hold its annual meeting in Boston during the week of August 25. Organized in New York in 1936, the objective of the College is to influence and encourage eminent service for the advancement of chiropody-podiatry, perpetuating the history and best traditions of chiropody-podiatry, and maintaining both the dignity and efficiency of the profession in its relationship to public welfare. The members consist of chiropodists (podiatrists) who have made notable contributions to the profession.

WHO'S WHO

THE BOOK of the chiropody profession containing a Who's Who of its members is now on the press. The committee reports that this book will be mailed to all subscribers and to the libraries, medical societies, and others designated

TWENTY-FIVE YEAR MEMBERS

FOLLOWING is a list of those who have received certificates in recognition of 25 years of continuous membership in the National Association of Chiropodists.

Awarded certificates in 1936:

CALIFORNIA: Carl Dehmel.

CONNECTICUT: Hattie Noll.

ILLINOIS: I. J. Reis (deceased), Nicholas Von Schill, Emma Burchard, Mrs. L. C. Edwards, Ella M. Roby.

MASSACHUSETTS: A. M. Brackett, Harry P. Kenison.

MICHIGAN: F. E. Jilek.

MISSOURI: Mrs. C. L. Glendore.

NEW JERSEY: Jacob Harris.

NEW YORK: E. K. Burnett, J. H. Callahan, Ernest Graff, J. R. Hillery, W. J. Karas (deceased), I. Mayer, M. Redell.

OHIO: Cordelia B. Knowles, Lenore Stevick, William R. Stone, U. E. Whiteis (deceased).

WISCONSIN: John M. Jackson.

Awarded certificates in 1939:

CALIFORNIA: Nelson Katz, George W. Scherer, Sr.

CONNECTICUT: Minnie Bellwood, Marie Danhauser, Katherine McCallum, Amanda E. Williams.

DISTRICT OF COLUMBIA: E. C. Rice.

FLORIDA: Harriet H. Danser (deceased), Otto J. L. Tonissen.

INDIANA: Arnold Elson.

MARYLAND: Regina M. Benzinger.

MASSACHUSETTS: Hiram B. Donaldson, Gilbert N. Pettingill, Fred T. Reiss, E. Robert Riedel.

MISSOURI: Hiram Clark.

NEBRASKA: Nellie Ryley.

NEW HAMPSHIRE: Elizabeth J. Kimball.

NEW JERSEY: A. Mathilde Miller.

NEW YORK: Joseph C. Arbogast, Martha D. Babcock, Myra Black, Peter A. Buhl, Vincent DeSio, Mary T. Foster, Reuben H. Gross, Edith Otis Mann, Frank J. Miletti, Anna J. Moyde, Frederick Schmitt, Bessie Shultes, Joseph Solomon, Simon P. Tiernan, J. H. Weiderman.

NORTH DAKOTA: Ida M. Melin.

OHIO: Cecil P. Beach, Nancy A. Beach, Max S. Harmolin, Charles Spatz, Arthur J. Thorman.

PENNSYLVANIA: James R. Bennie, Idah R. Finkbeiner, Adam M. Hall, Louise Jochinke, Ella J. D. McKee, Mary C. Morris.

TEXAS: John A. Herschel.

VIRGINIA: Walter E. Ellis.

WEST VIRGINIA: William C. Moorman, Walter C. Viehman.

DR. A. R. MORLEY, N.A.C. Secretary, suggests these members form a 25 Year Club to get together at conventions. The National Secretary will be glad to help any who are interested in getting this club going. Additional certificates are to be awarded this year.

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by them about August 20. Those who have not subscribed to the book but who desire a copy for their own library, may obtain a copy by sending $1 to the Massachusetts Chiropody Association, 58 Winter Street, Boston, Mass. Only a limited edition is being printed, to take care of those who have subscribed to the book. A few extra copies will be available for those who wish to order them at once.

TEMPLE CHIROPODY SCHOOL

[Continued from last issue]

GRADUATES

D.S.C. Degree—Benjamin Brody, Jerome Brand, David Burger, Verdin Smith Cantrell, Sydney G. Cohen, Philip Robert Coren, James Cucinotta, Stephen M. D'Orta, David Esrov, Stanley S. Fedder, Jerry S. Fields, Ralph W. Feeser, Leonard David Fuller, George James Garrod, Herman Goldberg, Belle W. Gordon, Abel Gorfain, William Eugene Goyette, William Green, I. Daniel Greenfield, Matthew Francis Gutowicz, Theodore Alfred Hansen, Stanley Morton Hornstine, Samuel Katz, Louis N. Keiserman, Theresa Marguerite Keogh, Harold L. Koshland, Sidney H. Lindenbaum, William G. Lowman, Andrew L. Magazzu, Charles Alfred Markel, Jr., John James Francis McGauran, Gilbert Miller, Alice Rebecca Morris, Paul R. Quintavalle, Russell Slayton Noyes, Joseph Albert Riccio, Daniel Irving Samuels, Howard Bentley Seyfert, Jr., Arthur Sharpe, Albert Harold Sher, Raymond William Shore, Sidney C. Sivitz, Frank Alexius Sliwinski, Abraham A. Snyder, Irene Elizabeth Todd, George Milton Tomlinson, Jr., Frederick Paul Weichel, Martin Wolgin, Nathan Yaffe.

G.Cp. Degree—George Ball, Alvin Berger, A. Isadore Gordon, Frederick Leland Peck, Leon Sandler.

Voice of the Profession

12 POINT PODIST PROGRAM

GEORGE C. CUSTER
Chicago, Ill.

1. ONE NAME. A name that is easily pronounced and accepted by the vote of ¾ths of the licensed chiropodists and podiatrists of America.

2. A UNIFORM DEGREE. Also accepted by ¾ths of the licensed chiropodists, podiatrists of America. (Perhaps we should include Canada too)

3. Pre-chiropody in a college of liberal arts.

(B) A four year chiropody course required by the law of each state.

4. Laws broad enough in their scope to allow the chiropodists, podiatrists full latitude to legally do *ALL* things necessary to cure, eradicate, alleviate, or correct *ALL* local diseases and deformities the human foot and hand is heir to either congenitally or acquired.

5. State laws that require no less than thirty days of *POST GRADUATE* work by all licensed chiropodists, podiatrists each year.

(B) A re-examination every ten years. Eradication of those who do not keep up with modern progress in chiropody, podiatry.

6. State laws prohibiting the individual chiropodist, podiatrist from advertising price or any other information excluded by the code of ethics accepted by the A. M. A.

7. State laws compelling all licensed chiropodists, podiatrists to be members of their state association.

8. 100% cooperation between the chiropodist, podiatrist, physician, and dentist for the patient's benefit.

9. More harmonious cooperation between all chiropodists, podiatrists. Always a boost for the other fellow and never a knock.

10. A national educational program promoted by the N.A.C. through magazines, newspapers and other legitimate channels for the purpose of acquainting the public with the scope of chiropody, podiatry and its relationship to their general health, mental and physical efficiency.

11. (A) Commission in the Army, Navy, and Coast Guard for our professional service.

(B) Acceptance of Chiropody, Podiatry by the Public Health Service and U. S. Veterans Administration.

12. Acceptance of chiropody, podiatry by the public for their foot ailments in the same category and relationship that dentistry bears to medicine.

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HONORS ARE DUE

THE OLDEST worker in point of service to the National Association of Chiropodists is not a chiropodist but a layman, none other than Fred H. Sidney, publicity man, known to all who ever attended an N.A.C. convention as Sidney or just Sid.

Sidney went to work for the N.A.C. during the first convention held in Boston back in 1914, the third N.A.C. convention. It was at this convention that the first ethical publicity was obtained. Previous conventions were held in Chicago and New York where newspapers called chiropodists 'corn cutters', 'corn scrapers', and published cartoons of weird looking fellows with a knife chasing corns. Sidney has

done more than any other individual to help put the profession on the map. He worked with Dr. Kenison, Dr. Stanaback, and Dr. Graff in the early days. He has since attended all conventions of the N.A.C. with the exception of 1921 at San Francisco. Being a member of the Brotherhood of Railroad Employees, he travels to conventions on his vacation passes, contributing of his time, money, and vacations from regular employment as a railroad telegrapher all for the love of the N.A.C., the profession, and the many friends he has made among chiropodists.

Sidney relates that as long ago as 1914 Drs. Kenison and Stanaback were trying to get chiropodists in the Army and Navy. During that year the present Senator, David I. Walsh, was Governor of Massachusetts, Drs. Kenison, Stanaback, Graff and Sidney went as a committee to see Governor Walsh about a chiropody law.

At N.A.C. conventions chiropodists know Sidney as the man who sends news items to the home town newspapers; he serves also as a liaison officer between the newspaper reporters and the officers of the N.A.C. Always willing to do a favor for any of us he asks nothing in return, although budget committees have seen fit to include a small honorarium to defray part of the postage stamps he uses each year in his regular contacts with newspapers everywhere.

Sidney has given over twenty-five years of continuous service to the National Association of Chiropodists. He is a part of every convention. He knows so much about chiropody that many newspaper men address him as 'Dr. Sidney'.

PUBLIC INFORMATION

From the Annual Report submitted to the Podiatry Society of the District of Columbia, by Jerome M. Fischgrund, Committee Chairman

AN ORGANIZED public information program is necessary in this or any other city for several reasons. The increase in practitioners is inevitable. It therefore becomes important to further educate the public to foot health in order not to create economic stress to old and new practitioners. In most cases it is economic stress that leads to neon signs, clinics and advertising. We the society urge the new man to be completely ethical. We in turn, owe him the obligation to better acquaint the public with Podiatry's place in foot health. If the public's interest is aroused, more foot care will result and by the law of averages the new practitioner can hope to get his share.

Public Information is our best weapon to keep the unsuspecting foot sufferer away from the arch expert and the charlatan. It is our best argument, when the facts are known and understood, to convince the advertiser that his money is being spent ineffectively.

At the beginning of the year, the committee made a study of the subject before engaging upon any activity that would bring discredit upon the society or lay any member open to the question of personal, rather than professional publicity. The committee concluded that the foundation for an effective program could be laid for the present and future within the word and spirit of the N. A. C. code, in good taste as befits a dignified calling, and within the budget of a small society as we are.

Our local committee was doing the job that an up-to-date, efficient N. A. C. office should be doing for them and hasn't done. No wonder

that member societies are critical of some of the N. A. C. committees.

The N. A. C. Public Information Office has been cooperative within its ability, and that ability is far below par. This is not to be construed as a personal criticism of Dr. Johanson. In the last few years this national office has been headed by sincere men who have been appointed to the position for geographical or other reasons, rather than for their pure ability and experience in public information work. In addition, this office has operated on a budget far below its most meager necessities. From our survey, our committee believes that $2,000 a year is the minimum amount necessary for an efficient N. A. C. public information office, provided it is properly run. This amount is less than one dollar per member. You can understand why this N. A. C. office lacked both vision and efficiency.

Your local committee had to plan its own convention publicity; learn the hard way how to compose press releases, wrack its brains for tie-ups on interesting happenings relative to foot health, compose its own foot health pamphlets, write all over the country to locate a decent group of film slides and our radio speakers had to scratch for material for the foot health talks; interesting and intriguing work, but inefficient. Multiply this by forty-eight and you have a repetition of wasted effort thruout the country.

If we had an efficient, visionary N. A. C. department, we should not expect it to do all the work for us. Public Information work would still be in the hands of the local and state committees. We would have an N. A. C. office that would co-ordinate the activities, write basic radio talks, teach the local men the technique of news releases, compose a series of slides for the member societies at cost, write basic foot health newspaper articles for adaptation to local use, compose basic foot health booklets for the local societies to print or mimeograph them in quantity, would have basic convention plans ready which when sent to convention chairmen, could be adapted for local use.

This office should be headed by a chiropodist who knows the art and technique of public information, and the ability to co-ordinate the local societies into a group of active men, all operating in the same manner, under a man who can and will feed them the necessary and vital material and encouragement.

The two thousand dollars will cover his secretarial and running expenses, and will allow him a few dollars for the extra time and office space to do the job properly. Your Public Information Director is well acquainted with the tremendous amount of detail necessary for an efficiently running office.

I urge the Society to instruct our delegate to the Boston convention to present these facts to the assembled delegates, in a most forceful manner.

• • •

MILITARY AFFAIRS

HOPEFUL that more cooperation will be received than in the past, Harry L. Goldwag, Chairman of the Military Affairs Committee, has presented a new plan in an effort to obtain approval and passage of the bill to establish a Chiropody (Podiatry) Corps in the Medical Department of the Army. The greatest obstacle at present is the attitude of General James C. Magee (Surgeon General of the U. S. Army), who disapproved the bill now before the House Military Affairs Committee.

It is proposed that every chiropodist ask their medical friends and practising physicians to write to the Surgeon General of the U. S. Army, urging adoption of the bill to provide foot care by chiropodists (podiatrists) for the men in the service.

• • •

PRACTICE BUILDING SUGGESTIONS

SHEER SILK stockings are often a walking advertisement, good or otherwise, for the chiropodist. Perhaps you have seen crudely bandaged feet and ankles exhibited through sheer silk hosiery. Moral: make every dressing effective, make it also a work of art.

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IF YOU HAVEN'T ALREADY, by all means visit the N. Y. World's Fair. Those on the west coast cannot afford to miss the Golden Gate Exposition.

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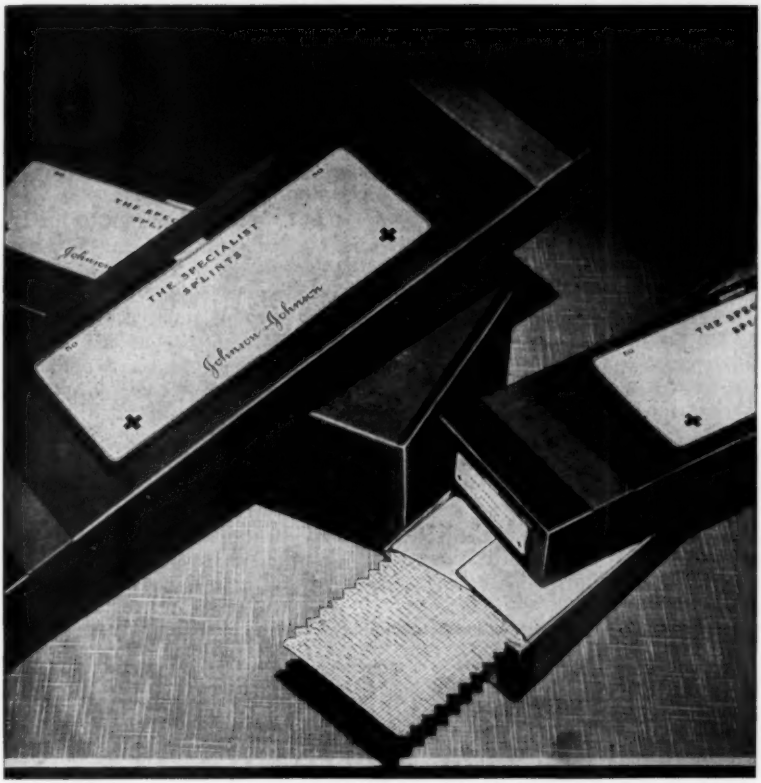
. . . *Reading from page 19*

admissions officers of medical colleges, and in part to the enthusiasm of college science departments, have devoted almost the whole of their college years, whether they have been two, three or four in number, to heavy concentration in science, particularly chemistry and biology. One-sided devotion to a single subject or field may be stimulating and functionally useful for some students, but the average student will lose, educationally, more than he gains by such a program. Most students will be more effectively educated as the result of a study of literature, the languages, the social sciences and philosophy. I trust that for the study of podiatry students will be sought and chosen who are, as far as possible, educated men and women. To this end freedom, outside the minimum prescriptions, should be accorded each student to plan his work in accordance with his own interests and aptitudes.

In regard to the requirements for professional study, up to 1938 the Regulations of the Department were more lenient than the requirements of the First Institute of Podiatry. The latter institution had required the completion of a three years' course while the regulations prescribed a minimum of two years. In this respect, as in the requirements for admission, the First Institute had moved forward voluntarily. The law of 1938 confirmed the practice of the First Institute and directed that the Commissioner of Education should accept as satisfactory only professional courses covering three years of study. So far as my information goes, this leaves the New York school the only one in the United States which may be legally recognized by the Department of Education at the present time. It is to be hoped that similar institutions in other states will, without too great delay, follow the lead of New York.

The law of 1938 required that the completion of the professional course in podiatry be marked with the degree of doctor of podiatry. The legal requirement of this degree has already had a profound effect upon the institutional organization for the study of podiatry, and is destined, I trust, to have far-reaching effect upon the course and development of the profession. The charter of the First Institute of Podiatry did not extend to it the power to confer degrees. Subsequent to the establishment of that School, stringent legal requirements had limited the power of the Board of Regents to confer the power to grant degrees upon educational institutions. It appeared that it would be impossible for the First Institute to meet certain of these formal requirements. This situation threatened for a time largely to nullify the effectiveness of the progressive legislation of 1938 by taking out of circulation the first and best school of podiatry in the country. No one will doubt that this result would have been a catastrophe. The solution came with the agreement between the First Institute and Long Island University, by which the former became a constituent school of the latter, with proper safeguards for all legitimate interests concerned. Coincident with the consummation of this arrangement, the Board of Regents amended the charter of Long Island University, authorizing it to grant the degree of doctor of podiatry, while at the same time the Board included this degree in its list of approved degrees. It is assumed that this degree will be granted for the first time to students who have satisfied all the statutory and departmental requirements in the spring of 1943.



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A word about degrees in general and the doctor of podiatry in particular. The American people are degree-mad. It has been said, and one is often tempted to believe it, that degrees have done lasting harm to the cause of education in the United States. The mere symbol has become identified in the public mind with the substance—the knowledge, training, experience, and wisdom that come from instruction and study. But a degree as such no more adds to educational or professional stature than the stamp of the eagle upon base metal makes a coin of worth. It is the solid educational substance behind the degree that gives it value and long-term recognition. Long Island University and the First Institute of Podiatry have jointly undertaken a great responsibility to make the professional study of podiatry fully worthy of the dignity and significance of the degree which will mark its completion. The record of the First Institute of Podiatry has been an enviable one. It has long been by far the best school of its kind in the country, but no one, least of all your loved and respected founder, Dr. Lewi, would assert that it could not be improved. To a vigorous program of added strength and progressive improvement I am certain that the staffs of both institutions will dedicate themselves, and in this they will need and deserve the wholehearted and united support of this Society. If this be done, the legislation of 1938 will be marked as an outstanding milestone in the history of your profession.

It is unfortunately true that the degree of doctor of podiatry will in any case fail to secure full recognition so long as it continues to be based upon an educational program less extensive and complete than

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that leading to other and older doctorates. At the present time no other doctor's degree is awarded in course except upon the completion of at least six post-secondary-school years of study. This standard should be set as a worthy goal to be striven for by this profession.

To secure a license to practice podiatry, as most of you know from practical if not sad experience, it is necessary not only to complete the preliminary and professional educational requirements, but to pass the licensing examinations. At this point the Department of Education rests its case upon the sound judgment and unswerving devotion to duty of the Board of Examiners in Podiatry. These five public-spirited men, without material remuneration, devote many days in the course of the year to the onerous task of preparing examination papers that shall be searching and discriminatory and at the same time wholly fair. Let anyone who doubts the difficulty of this undertaking try his own hand at the construction of intelligible unambiguous test items. He will find that it is vastly harder to ask effective questions than to answer them.

That much progress is yet to be made in the development of better licensing examinations must be readily admitted. The examination has a single purpose—to discriminate accurately between the competent and the incompetent in the practice of the profession. To accomplish this objective the examinations should test more than mere book learning, and should be more than repetitious of examinations passed in school. For this reason, the Department cordially supports the Board of Examiners in their decision to institute a series of practical examinations so that they may judge of fitness not only by what the candidate knows, but even more important, by the way he puts his knowledge to effective

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use. Dickens' lampoon of the Yorkshire school, in Nicholas Nickleby, horrible though the picture is, contains the germ of sound educational doctrine. Squeers, the ignorant and scoundrelly schoolmaster, upon being told that one of the boys is cleaning a window, explains: "We go upon the practical mode of teaching. C-l-e-a-n, clean, verb active, to make bright, to scour. W-i-n, win, d-e-r, der, winder, a casement. When the boy knows this out of book, he goes and does it." The Board of Examiners proposes, metaphorically, to have the candidates clean winders.

In appraising the activities of the Department and of the Board of Examiners in granting or denying the license to practice, it must be borne in mind that a public responsibility rests upon the Board to admit to the profession only those who have fully met the highest standards of professional conduct. There is no inherent right vested in any individual to be permitted to practise as a podiatrist. Here the public interest far transcends the interest of any individual or group. In this connection it should be noted that for the enforcement of one legal requirement for licensure—good moral character—the Department and the Board depend largely upon the discriminating judgment of the school. To all intents and purposes, we must rely upon the school to send us only candidates who will be worthy of professional responsibilities. It, therefore, becomes the obligation of the school ruthlessly to discard any student who fails to evidence an understanding of and a respect for the code of conduct that marks an American gentleman. A strict adherence to the basic principles of morality, always essential to intelligent living, was never, in all the history of the world, more desperately needed than now.

The fact that the dependence of the Department upon the school for the selection of professionally minded candidates for licensure has not been misplaced is shown by the relatively few instances when the Board of Examiners is called upon to resort to disciplinary measures with members of the profession. It should be said that when occasion has arisen to require the Board to exercise its quasi-judicial functions it has done so with wisdom and courageous decisiveness. But in the last analysis, neither the schools, nor the Department, nor the Board can enforce good professional conduct. In the profession, as in the community at large, police and judicial powers are effective only after the establishment and general acceptance of a code. No law or rule can be enforced until it is voluntarily observed by all but an insignificant

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minority. It is for the profession, and for professional organizations such as this one to create a professional public opinion which shall be so devastatingly condemnatory of unprofessional conduct as to make a violation of the accepted code of professional ethics unthinkable. It is clearly your responsibility to create such a professional atmosphere that each year's group of new licensees will absorb from every contact with their fellow practitioners a clear sense of their high public duty. You are, in a real sense, your brothers' keepers.

You will have inferred, I hope, from what I have said, that the Department of Education assumes its responsibilities in respect to your profession, as in respect to all others, with the protection of the public interest as its main objective. The Department cannot be concerned primarily with the welfare of individuals. Officers of the Department are constantly called upon to deny requests for preferred treatment for individual petitioners, not because they are callous to the interests of the persons involved, but because their legal and official responsibility to the public overpasses every other consideration. In the same way, and for the same reasons, the Department is not mainly concerned with the limited guild interests of professional groups. The Department does not assume that the protection of a license has been extended to any professional group for the promotion of the economic welfare of that group. Every professional licensing law is based squarely upon the police power of the State—that is the power of the State to protect the *public* health and safety. In the administration of the professional laws, the Department must, therefore, have an eye single to the protection of the public interest. However, it is our firm conviction that to the extent to which we succeed in this objective we most effectively promote the welfare of every individual professional man and woman. So I leave with you this thesis: as you, the members of a profession, devote yourselves single-mindedly to the public welfare, you best advance and protect your own.

*Read by Mr. Charles B. Heisler, Director, Professional Licensure Division for the State of New York, at the Annual Banquet of the Podiatry Society of the State of New York at the Hotel Pennsylvania, New York City, on Monday evening, May 13th, 1940.

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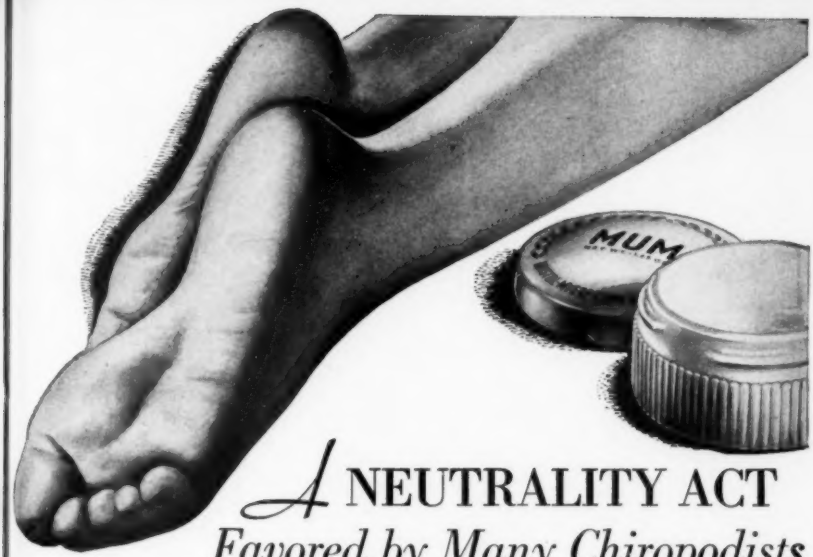

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